



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

METHODIST HOSPITAL
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-09-A955-01

MFDR Date Received

JULY 30, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the Provider requested reimbursement for implants so the Carrier should have paid this claim at 108% + implants (at cost plus 10%). That would have entitled the provider to \$71,309.56 in reimbursement. The Carrier only paid \$30,499.99. Therefore, the Provider contends an additional \$40,809.57 remains owed. The Carrier on this claim incorrectly factored the Medicare Inpatient Pricing rate at \$21,328.67 and paid 143% of that rate at \$30,499.99. The outlier provisions generated extra Medicare reimbursement. Therefore the total Medicare Inpatient Pricing rate is \$35,301.45. The provider has requested 108% + implant reimbursement. Therefore the total that should have been paid on this case is \$71,309.56...it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case."

Amount in Dispute: \$40,809.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a response to this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2008 Through August 9, 2008	Inpatient Hospital Surgical Services	\$40,809.57	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and

voluntary certification of health care.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits with the listed date of audit September 26, 2008

- CAC-18 — Duplicate claim/service.
- 224 — Duplicate charge.

Explanation of benefits with the listed date of audit October 14, 2008

- CAC-W1 — Workers Compensation State Fee Schedule adjustment.
- CAC-62— Payment denied/reduced for absence of or exceeded pre-certification/authorization.
- CAC-97— The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217— The value of this procedure is included in the value of another procedure performed on this date.
- 468— Reimbursement is based on the Medical Hospital Inpatient Prospective Payment system methodology.
- 711— Length of stay exceeds number of days previously preauthorized.
- ***Preauthorization was obtained for 2-3 days only. It does not appear an extension was sought.

Explanation of benefits with the listed date of audit December 17, 2008

- CAC-W1 — Workers Compensation State Fee Schedule adjustment.
- CAC-W4— No additional reimbursement allowed after review of appeal/reconsideration.
- CAC-62— Payment denied/reduced for absence of or exceeded pre-certification/authorization.
- CAC-97— The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217— The value of this procedure is included in the value of another procedure performed on this date.
- 468— Reimbursement is based on the Medical Hospital Inpatient Prospective Payment system methodology.
- 711— Length of stay exceeds number of days previously preauthorized.
- 891— The insurance company is reducing or denying payment after reconsideration.
- ***Preauthorization was obtained for 2-3 days only. It does not appear an extension was sought. Payment was allowed at 143% for 3 days. Reimbursement made in accordance with Rule 134.404(F)(1). Separate reimbursement for implantables was not requested in accordance with Rule 134.404(G).

Explanation of benefits with the listed date of audit February 5, 2009

- CAC-W1 — Workers Compensation State Fee Schedule adjustment.
- CAC-18 — Duplicate claim/service.
- CAC-62— Payment denied/reduced for absence of or exceeded pre-certification/authorization.
- CAC-97— The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217— The value of this procedure is included in the value of another procedure performed on this date.
- 468— Reimbursement is based on the Medical Hospital Inpatient Prospective Payment system methodology.
- 711— Length of stay exceeds number of days previously preauthorized.
- 878— Duplicate appeal. Request Medical Dispute Resolution through DWC for continued disagreement of original appeal/decision.
- ***Preauthorization was obtained for 2-3 days only. It does not appear an extension was sought. Payment was allowed at 143% for 3 days. Reimbursement made in accordance with Rule 134.404(F)(1). Separate reimbursement for implantables was not requested in accordance with Rule 134.404(G).

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Which reimbursement calculation applies to the services in dispute?

4. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
5. What is the maximum allowable reimbursement for the services in dispute?
6. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. Review of the respondent's preauthorization approval letter dated <au 29. 2-008 identifies that approval was obtained for Lumbar Decompression/Stablization at L1-2, L2-3 to include CPT codes 22612, 22614, 63047, 63048 and 63048 for 2-3 days length of stay under authorization number 2198988 with a start date of May 28, 2008 and an end date of June 28, 2008. The authorized date range does not include any of the disputed dates of services, July 30, 2008 through August 9, 2008, however the explanation of benefits indicate that the respondent reimbursed the requestor for the first 3 days of the inpatient stay, consistent with the original preauthorization.
3. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

4. Review of the submitted documentation finds that separate reimbursement for implantables was not requested in accordance with 28 Texas Administrative Code §134.404(g). Although the requestor submitted the bill with the certified implant invoices to the insurance carrier, the requestor did not formally request, in writing, separate reimbursement for the implantables.
5. 28 Texas Administrative Code §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is DRG 460, and that the services were provided at Methodist Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$21,328.67 for dates of service, July 30, 2008, July 31, 2008 and August 1, 2008, consistent with the original preauthorization. Disputed dates of service August 2, 2008 through August 9, 2008 were not preauthorized, therefore were not considered in this review. This amount multiplied by 143% results in a MAR of \$30,499.99.

Therefore, the total allowable reimbursement for the services in dispute is \$30,499.99. The respondent issued payment in the amount of \$30,499.99. As a result, the requestor is entitled to \$0.00 additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ November 27, 2012 Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	_____ November 27, 2012 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.